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Published in:
British Journal of General Practice

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
2007

[Link to publication in University of Groningen/UMCG research database](#)

Citation for published version (APA):

van Heest, F., Finlay, I., Otter, R., & Meyboom-de Jong, B. (2007). The new millennium palliative care project (2000-2003): the impact of specialised GP advisors. *British Journal of General Practice*, 57(539), 494-496.

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The New Millennium Palliative Care Project (2000–2003): the impact of specialised GP advisors

Florien van Heest, Ilora Finlay, Renée Otter and Betty Meyboom-de Jong

ABSTRACT

This study describes a novel type of support for GPs caring for patients dying at home: the establishment and evaluation of a telephone advisory service for GPs, run by GPs with a special interest in palliative care (GPwSIs) in the Netherlands 2000–2003. A growing number of GPs called for advice, 10% during out of hours. Prognosis of the patients was generally short (days to weeks in 70% of cases). Most advice sought by GPs concerned symptom management and on evaluation, 85% of the GPs followed the advice.

Keywords

advisory services; family physicians; palliative care; quality of health care.

INTRODUCTION

In 1998 the Dutch government initiated a national programme to stimulate service development and improvement in the quality of palliative care. The development of consultative facilities for professional carers was part of this programme.

The aim of this project was to organise rapid access to palliative care advice for all GPs caring for patients dying at home in the region covered by the Comprehensive Cancer Centre North-Netherlands (CCCN). This region is a predominantly rural area with a population of 2.1 million, about 1000 GPs, 17 hospitals (one university hospital) and 5500 cancer deaths per year.^{1,2} Access to cancer therapy and disease-modifying therapy is well organised. Sixty-one per cent of all patient deaths in 1998–1999 occurred at home.³ In 2000, the area had neither hospices nor nurses or doctors working as specialists in palliative care.

The research questions were to determine to what extent the service was used, for whom and by whom, what type of problems were discussed, whether the advice was followed by the GP, and whether the advice made a difference to the quality of care, according to the GP.

METHOD

Four GPs with a special interest (GPwSIs) in palliative care were appointed in the different sub-regions for 1 day per week in addition to their normal activities as a GP (September 1999). All four obtained the Diploma in Palliative Medicine in 2001 at Cardiff University UK; they acted as a team, met regularly and discussed problems openly.

An educational programme in pain management and the subcutaneous administration of drugs was developed to promote the advisory service, and offered to every GP out-of-hours consortium in the region covered by the CCCN. Within 2 years this programme was presented to almost all GPs in the area. The GPwSI advisors were available out of hours. The use of telephone advice made the GPwSI rapidly accessible, and the process of obtaining advice time efficient.

All telephone advice calls from 2000–2003 were

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Submitted: 24 June 2006; **Editor's response:** 22 August 2006; **final acceptance:** 20 November 2006.

©British Journal of General Practice 2007; 57: 494–496.

documented (data on the GP and the patient including Eastern Cooperative Oncology Group [ECOG] performance status, the type of problem and the advice given). The impact of the advice was evaluated by standard questionnaire to the GP after 2–6 weeks.

RESULTS

The number of calls for advice increased each year starting with about 100 calls in the first year (Figure 1). Calls lasted 15 minutes (mean) and sought advice on patients of all age groups (mean age 62 years, range 0–100 years), usually in the last phase of illness. Over 10% of the calls sought advice out of hours. Twenty-four per cent of patients had lung cancer. The involvement of formal nursing care increased from 76% in 2000 to 81% in 2003. The ECOG performance status, as assessed by the person seeking advice, was 4 (= completely bedridden and dependent) in 48% of the patients.

GPs presented a mean number of 1.3 problems per patient (median = 1), but after discussion a mean of 1.9 problems (median = 2) was revealed; 70% of the presenting problems concerned symptom control (pain 38%, nausea and vomiting 20%, and delirium 10%), and 13% concerned drug management (Table 1). Further symptom control and other problems became evident during discussion.

The use of subcutaneous infusions at home increased with time from 111 in 2000 to 418 (three regions) in 2003 (data were incomplete data for the fourth region).

The response rate for the evaluation questionnaires was 68% (947 of 1389). Responders were representative of GPs in the area; 60% were born between 1951 and 1966 (26% born before 1950), 68% were male, 63% worked full-time; 47% worked in the city and 53% in a rural area. They had worked as GP for <1–35 years (mean 12.9 years).

In 85% of the cases the advice was followed, and in 11% it was followed in part; 4% did not follow the advice. Eighty-six per cent of those seeking advice

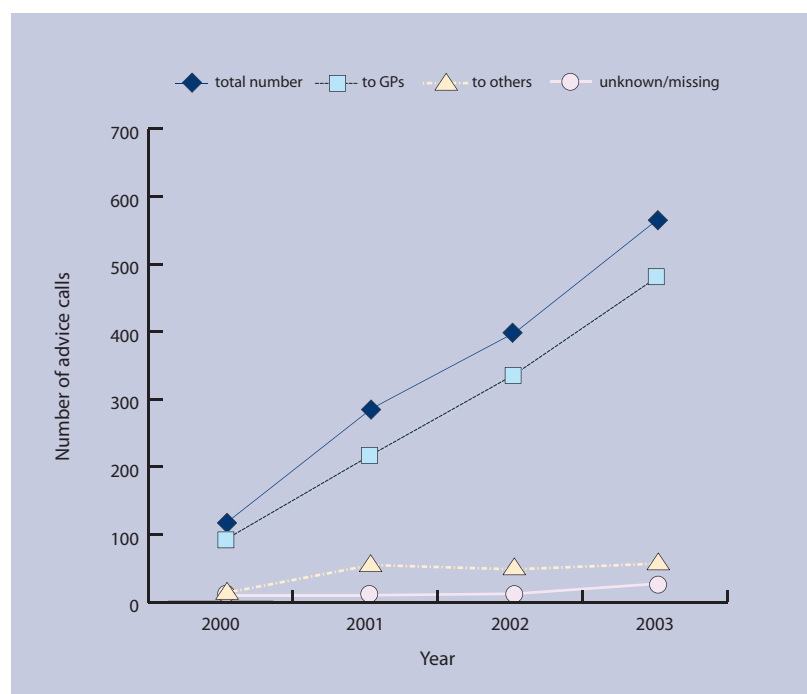


Figure 1. number of advice calls given by GPwSI 2000–2003.

thought that the advice was useful; 84% of responders felt that the advice had improved the quality of palliative care.

DISCUSSION

The increasing number of calls for advice suggests that the advisory service fulfils a need of GPs. Most sought advice on symptom management, but discussion revealed additional problems in over half of the calls, suggesting the importance of an exchange of thoughts in discussion. The advice given by the GPwSI adviser was evaluated as positively contributing to care.

As this service responded to the needs of the GP, outcome at patient level could not be reliably measured.⁴

Table 1. Type of problems discussed during the advice calls.

Subject	Presenting problems	Revealed problems
Pain	509	501
Other symptoms	794	859
Pharmacotherapeutics	238	476
Psychological problems	68	116
Existential problems	20	40
Social problems	25	56
Technical medical problems	70	160
Organisational problems	25	87
Communication problems	23	78
Problems with planning	30	103
Need for confirmation	31	142
Problem of the doctor	22	65

How this fits in

Many patients with a progressive life-threatening disease wish to die at home; for different reasons this is often not achieved. In this descriptive study the GP is supported in delivering palliative care by GPwSIs round-the-clock. Advice to GPs in the present study was followed (85%) and evaluated as useful (86%).

When this advisory service was instigated, no study had compared different team models in palliative care.⁵ The assumption was made that to support GPs in palliative home care the appointment of GPwSIs would be more appropriate. This would result in more deaths at home than with the establishment of a hospital-based multidisciplinary team. Kuin *et al*⁶ found that advice from 19 hospital-based teams was sought for patients with a longer prognosis than the patients in the present study,⁶ and Klinkenberg *et al*⁷ reported that almost half (49%; $n = 84$) of terminally ill Dutch patients were moved to hospital to die, with 39% of admissions less than a week before death. The round-the-clock support of the GPs in the present study may be key in supporting patients dying at home, but further study is needed to evaluate this.

Funding body

This project and study was funded by grants from the Dutch Ministry of Health

Ethics committee

Not applicable

Competing interests

The authors have stated that there are none

Acknowledgements

The fellow workers of the department of Palliative Care, especially the other GPwSI advisers (Paul Cost Budde, Christa Rolf and Karel Schuit) of the CCCN and the GPs in the area are acknowledged for the registration and evaluation of the consultations.

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